Description	Fee Per Unit of Service
(1) Initial Development of Support Services Plan. Only one unit of service may be reimbursed per participant, except that a new plan may be necessary when an individual is re-enrolled after a break in service.	$450
(2) Ongoing Case Management. Only one unit of service may be reimbursed for a participant during a calendar month. However, the unit may be reimbursed for the same date of service as the initial development of the support services plan. A unit of service may not be billed before the end of the month of service and unless all of the covered services have been performed.	$50

9. Reimbursement may not be made for these services if the participant is receiving a similar case management service under another Medical Assistance Program authority.

Reimbursement Methodology - Case Management for Pregnant Substance Abusing Women

1. Requests for payment shall be submitted by an approved provider according to procedures established by the Department. The Department reserves the right to return to the provider, before payment, all invoices not properly signed and completed.

2. The provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

a. Date or dates of service;

b. Participant's name and Medical Assistance number;

c. Provider's name, location, and provider number; and

d. Nature, unit or units, and procedure code or codes of covered services provided.

3. A unit of service is defined as at least one contact in person or by telephone by the case manager with the participant, as well as the provision of all other necessary covered services.

4. The provider shall bill the Program for the appropriate fee or fees specified in #7.

5. The Program will make no direct payment to recipients.

6. Billing time limitations for services shall be the same as those set forth in COMAR 10.09.36.

7. Payment shall be made:

a. Only to a qualified provider for covered services rendered to a participant; and

b. According to the following fee-for-service schedule:

Description	Fee Per Unit of Service
(1) Initial plan of service. (Only one unit of service may be reimbursed per participant upon the plan's completion.)	$250
(2) 3-month revision of plan of service. (Only one unit of service may be reimbursed for a participant every 3 months, upon the revision's completion.)	$250
(3) Ongoing case management. (Only	$150

one unit of service may be reimbursed for a participant during a calendar month. However, it may be reimbursed for the same date of service as an initial plan of service or 3-month revision. Billing may not occur before the end of the month of service and until all of the appropriate covered services have been performed.)

8. Reimbursement may not be made for these services if the participant is receiving a similar case management service under another Medical Assistance Program authority.

Reimbursement Methodology - Case Management for Children Diverted/Returned from Out-of-State Residential Treatment Facilities

1. Requests for payments for the covered services shall be submitted by an approved provider according to procedures established by the Medical Assistance Program. The Department reserves the right to return to the provider, before payment, all invoices not properly signed and completed.

2. The provider shall submit a request for payment in the manner specified by the Medical Assistance Program. The request shall include the:
   a. Date or dates of service;
   b. Participant's name and Medical Assistance number;
   c. Provider's name, location, and identification number; and
   d. Nature, procedure code or codes, and unit or units of the covered services provided.

3. The provider shall bill the Medical Assistance Program for the appropriate fee or fees specified in Item 7.

4. The provider shall accept from the Medical Assistance Program as payment in full for the services covered and make no additional charge to the participant or any other party.

5. Billing time limitations for these case management services are the same as those set forth in COMAR 10.09.36.06.

6. A unit of service means:
   a. For initial assessment and reassessment:
      (1) At least one contact by a case manager with the participant or the participant's representative,
      (2) A completed assessment or reassessment, and
      (3) The provision of all other necessary covered services;
   b. For Interagency Service Plan (ISP) development or revision:
      (1) At least one contact by a case manager with the participant or the participant's representative,

(2) A completed and signed ISP or revision,
(3) The case manager's or case management supervisor's convening and conducting an interagency team to develop or revise the participant's ISP, and
(4) The provision of all other necessary covered services; and

c. For ongoing case management:
(1) At least one face-to-face contact with the participant or the participant's representative per month,
(2) Contact in person or by telephone with service providers at least on a monthly basis,
(3) At least 10 hours per month spent on rendering ongoing case management for the participant, and
(4) The provision of all other necessary covered services.

7. Payment shall be made only to one qualified provider for covered services rendered on a particular date of service to a participant and according to the following fee-for-services schedule:

Description	Fee Per Unit of Service
(a) Initial Assessment. Only one unit of service may be reimbursed per participant.	$250
(b) Reassessment. Not more than six units of service per participant may be reimbursed in a 12-month period.	$ 50
(c) Interagency Service Plan Development or Revision. Not more than seven units of service per participant may be reimbursed in a 12-month period.	$135
(d) Ongoing Case Management. Only one unit of service may be billed during a calendar month. A unit of service may not be billed before the end of the month of service and unless all of the covered services have been performed.	$335

8. Reimbursement may not be made for these services if the participant is receiving a similar case management service under another Medical Assistance Program authority.

Reimbursement Methodology - Service Coordination for Children With Disabilities

1. Requests for payment for the services covered under Service Coordination for Children with Disabilities must be submitted by an approved provider of Service Coordination for Children with Disabilities, according to procedures established by the Medical Assistance Program. The Program reserves the right to return to the provider, before payment, all requests not properly completed.

2. A provider shall:

a. Bill the Program for the appropriate fee or fees as specified in Item # 3 below;

b. Accept payment from the Program as payment in full for the covered services under Service Coordination for Children with Disabilities and make no additional charge to the participant or any other party; and

c. Submit a request for payment in the manner specified by the Program, that includes the:

(1) Date or dates of service,

(2) Participant's name and Medical Assistance number,

(3) Provider's name, location, and identification number, and

(4) Nature, unit or units, and procedure code or codes of covered services provided.

3. The Medical Assistance Program shall pay only one qualified provider for covered services rendered on a particular date of service to a participant and according to the following fee-for-services schedule:

Description	Fee Per Unit of Service
a. Initial IEP or 504 WIP. Only one unit of service may be reimbursed per participant	$500
b. Ongoing service coordination. Only one unit of service per month may be reimbursed for a participant	$150
c. IEP or 504 WIP review. At most three units of service may be reimbursed for a participant in a 12-month period	$275

4. Payment may not be made for ongoing service coordination when, for the same month, payment is made to the provider for furnishing to the participant either.

a. An initial IEP or 504 WIP service; or
b. An IEP or 504 WIP review service.

5. Reimbursement may not be made for these services if the participant is receiving a similar case management service under another Medical Assistance Program authority.

MENTAL HEALTH REHABILITATION SERVICES PROGRAM

Reimbursement Methodology

Providers participating in the Mental Health Rehabilitation Services Program ("Rehabilitation Program") are reimbursed at fixed rates established by the Department of Health and Mental Hygiene ("Department"). The Rehabilitation Services regulations, COMAR 10.09.59, state that the providers shall be reimbursed the lesser of the amount billed to the Medical Assistance Program; a rate specified in the regulations; or a rate established by the Department pursuant to COMAR 10.02.01.

The Department's regulations at COMAR 10.02.01.03 require the Department to establish a schedule of charges for services rendered by the Department and grantees of the Department. (The providers who will participate in the Rehabilitation Program will be grantees of the Department.) The regulations provide that the charges submitted by grantees shall be based on the best estimates of costs according to generally accepted accounting principles.

The rates under COMAR 10.02.01 for mobile treatment programs and outpatient community mental health programs operated by local health departments are developed by aggregating the costs of all local health department clinic services and calculating an average cost statewide. The rates under COMAR 10.02.01 for psychiatric rehabilitation programs operated by local health departments and by private organizations are developed by aggregating the costs for these programs and calculating an average cost statewide. The rates under COMAR 10.02.01 for privately operated mobile treatment programs and outpatient community mental health programs are calculated individually, with each provider's rate representing the cost of providing that service. For all providers, the rates set represent what the providers should charge the general public.

Utilization Review Program

The Department will implement a utilization review program to review the services provided under the different types of rehabilitation services contained in the Plan Amendment. This program will assure the medical necessity of all services for which Medicaid reimbursement is sought.